

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Amos			MIDDLE George			LAST Casey			2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH July			DAY 6,			YEAR 1980			2b. HOUR 8P.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH July			DAY 7, 1980			YEAR 19			2d. HOUR 2P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's Co. MD.														
10. CITY OR TOWN OF DEATH Grasonville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at his home in Grasonville Md.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman and painter						12b. KIND OF BUSINESS OR INDUSTRY								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																										
13a. STATE Md.				13b. COUNTY Q.A. Co.				13c. CITY OR TOWN Grasonville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS old Rt#18										
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dessie Casey																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-32-9978						17. INFORMANT ADDRESS grasonville, Md. Catherine Virginia Roe, Rt#1 Box#177														

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

4140  
Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4.5 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL  
SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE  
SIGNED

July 7, 1980

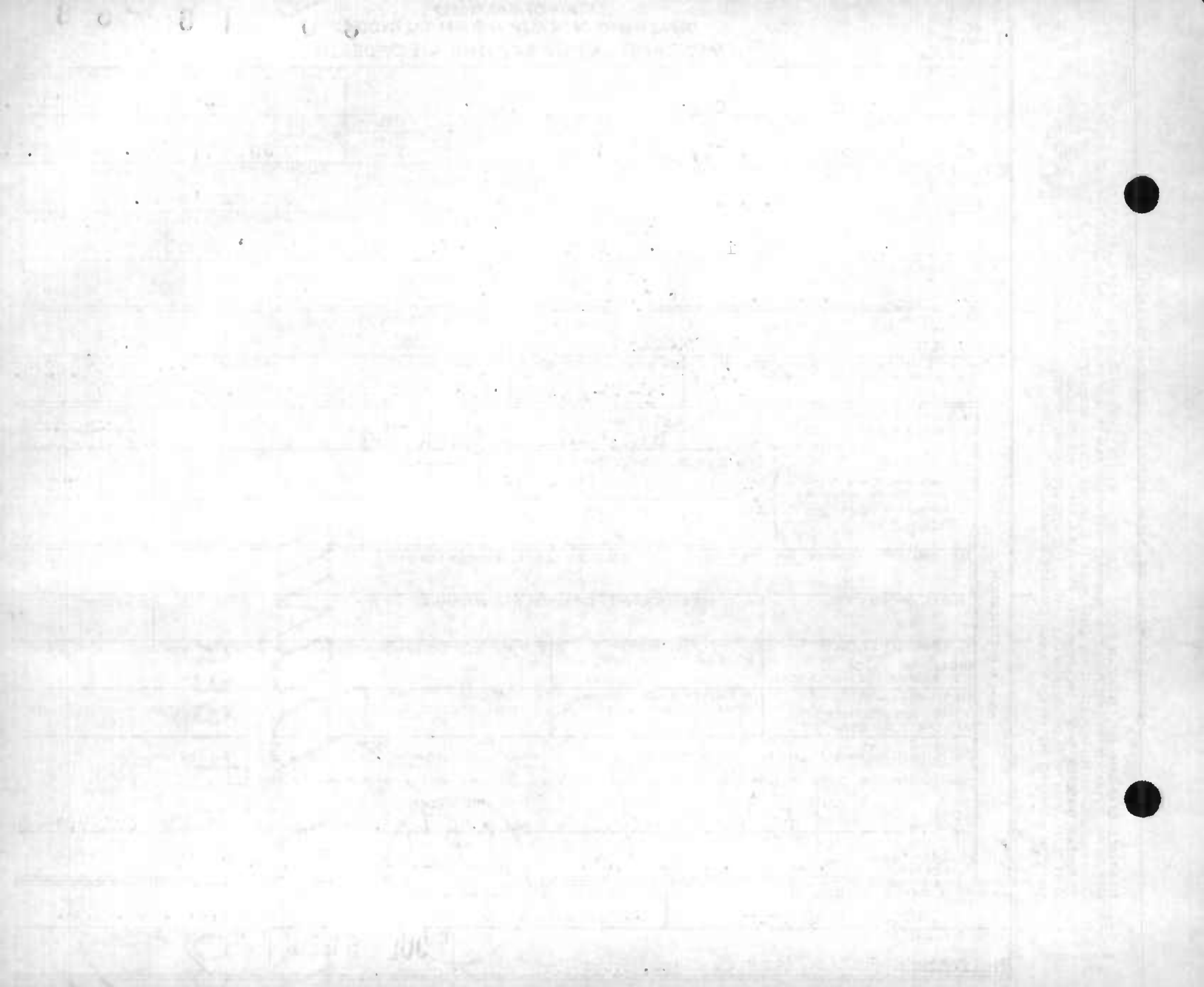
EXAMINER'S NAME  
(TYPE OR PRINT)

Dr. John R. Smith, Jr.

ADDRESS

Centreville, Md. 21617

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-9-80		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville, Q.A. Co. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Helfenbein-Hubbard Funeral Home, Rt#1 Box #66, Chester Md.				25a. DATE REC'D. BY REGISTRAR JUL - 5 1980		25b. REGISTRAR'S SIGNATURE	



Items 18 & 22a G546 8/20/80 dad STATE OF MARYLAND

FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 1 8 9 6 9

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			MONTH	DAY	YEAR	7b. HOUR
BETTY LOU COLEMAN						7- 29 19 80						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	7d. HOUR
female	white	Apr 3, 1933	47 YRS.			7- 29 19 80						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Md			U S A						Queen Anne's County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Chester			Rt. #2 Box 760P Chester, Md.			Tag & Title co			Self employed			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Md			Queen Anne			Chester			Box 760 P Skipper Lane			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Victor Fitzwater						Ina Rhodes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no				579 42 0227		Forrest A Coleman Chester, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism</u> 303- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Margrita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 7-30-80				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
Margrita A. Korell, M.D.				111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial				Aug 2, 1980		Ft Lincoln Cemetery		Brentwood Pro Georges Md.				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
F. Gasch's Sons P A Hyattsville, Md.						AUG 04 1980		<u>History, Maryland</u>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



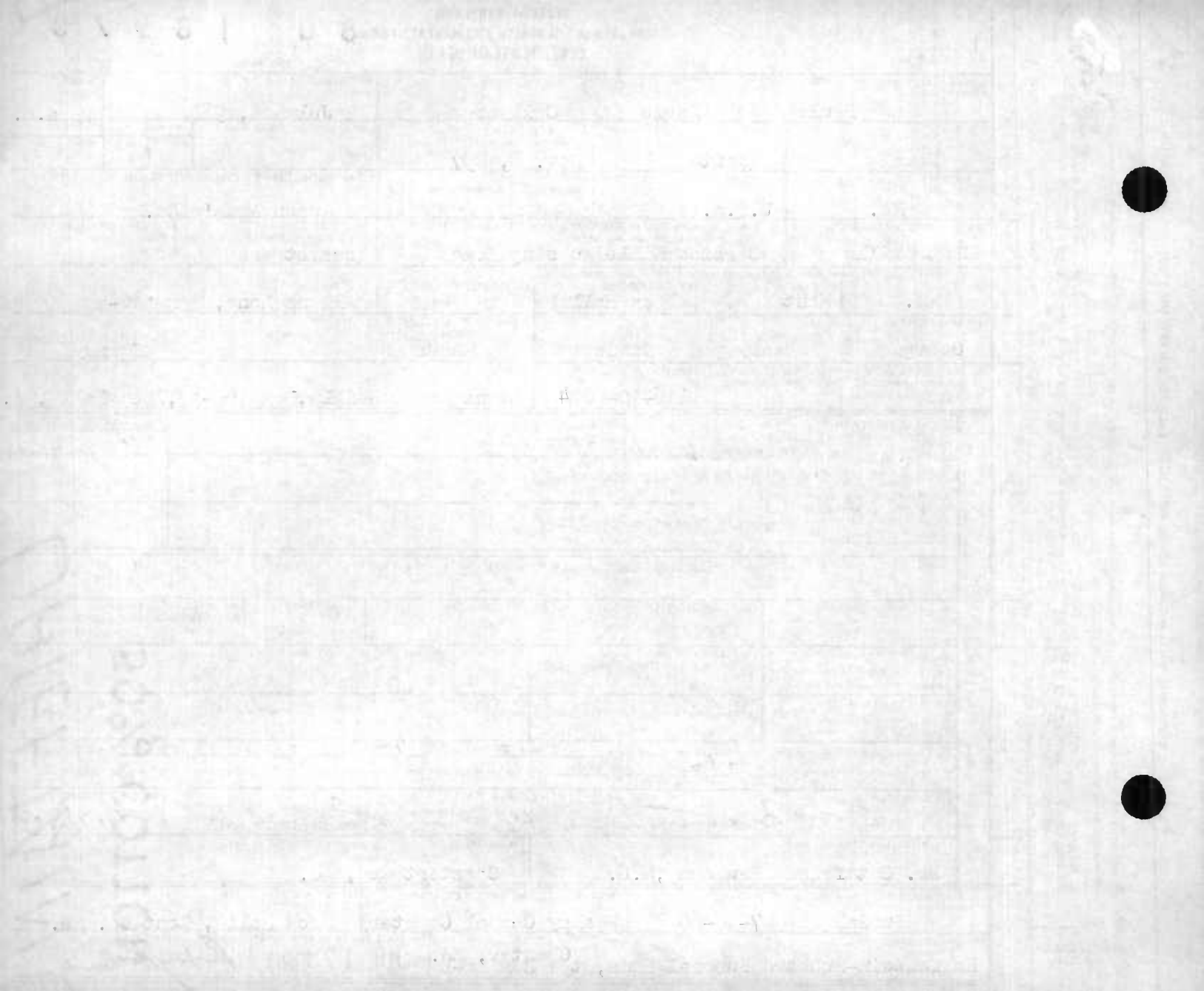
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 8 9 7 0			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beula Davis Collyer						2a. DATE OF DEATH MONTH DAY YEAR July 14, 1980				2b. HOUR 9 a.m.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 8, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's Co. MD.							
10. CITY OR TOWN OF DEATH Centreville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corsica Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Allens Lane, Box 180-A			
14. FATHER'S NAME FIRST MIDDLE LAST George Henry Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhoda Downey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-2004		17. INFORMANT ADDRESS Leona Davis Reihl, Box 180-A, Rock Hall, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASCVD</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 24</u> , 19 <u>74</u> , to <u>7/14</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7/12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Dr. Gottfried Baumann</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/17/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gottfried Baumann, M.D.						22e. ADDRESS Chestertown, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-16-80		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Kent Co. Md.							
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home, Rt. #1						ADDRESS Chester, Md.		25a. DATE REC'D. BY REGISTRAR JUL 17 1980		25b. REGISTRAR'S SIGNATURE <u>Barry McCreedy</u>			





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 8 9 7 1  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>Anna Mae Coppage</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1980</b>		2b. HOUR <b>12:30</b> MIN <b>P</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>May 28, 1882</b>		6. AGE (In years lost birthday) <b>98</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Queen Anne's Co.</b> Md.		
10. CITY OR TOWN OF DEATH <b>Sudlersville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) <b>Kitty's Dormacillary</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Q.A. Co.</b>	13c. CITY OR TOWN <b>Barclay</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Box #64</b>	
14. FATHER'S NAME First <b>Lake</b> Middle <b>Turner</b> Last <b>Turner</b>	15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Jarrell</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <b>217-54-5614</b>	17. INFORMANT Address <b>Charles Coppage, Box #64, Barclay Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease - 4/14/8</b> DUE TO, OR AS A CONSEQUENCE OF <b>with Myocardial Ischemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Fracture of Femur @ Organic Brain Syndrome</b>					
19a. DATE OF OPERATION <b>2/2/8</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture of Femur</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> , 19 <b>78</b> , to <b>July 17</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>June 10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Susan K. Ross MD</b>		DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE/SIGNED <b>7/18/80</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Susan Ross, M.D.</b>		22e. ADDRESS <b>Chestertown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-20-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Sudlersville, Q.A. Co., Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Helfenbein-Hubbard Funeral Home, Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 22 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18972	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Philemon <del>Philmore</del> A. Dickerson</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 7 1980		2b. HOUR <b>P</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/24/09</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>71</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7b. HOUR <b>11:50</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's County, MD</b>		
10. CITY OR TOWN OF DEATH <b>Centreville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Conquest Fair Beach</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waterman</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>						13b. CITY OR TOWN <b>Kent</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>RFD # 3</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Wesley Dickerson</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie E. Scheeler</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>218 10 4339</b>		17. INFORMANT ADDRESS <b>wife</b> <b>Ruth Dickerson RD 3 Chestertown</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8329 Drowning</b> IMMEDIATE CAUSE (a) } Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>? P.M. 7 7 1980</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 7 1980</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject fell out of boat and drowned</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>river</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Chester River Centreville, Queen Anne's, Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>7/8/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/11/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chestertown, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>J. Willis Wells</b>						ADDRESS <b>Chestertown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McBrady</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic events, the medical examiner must be notified at

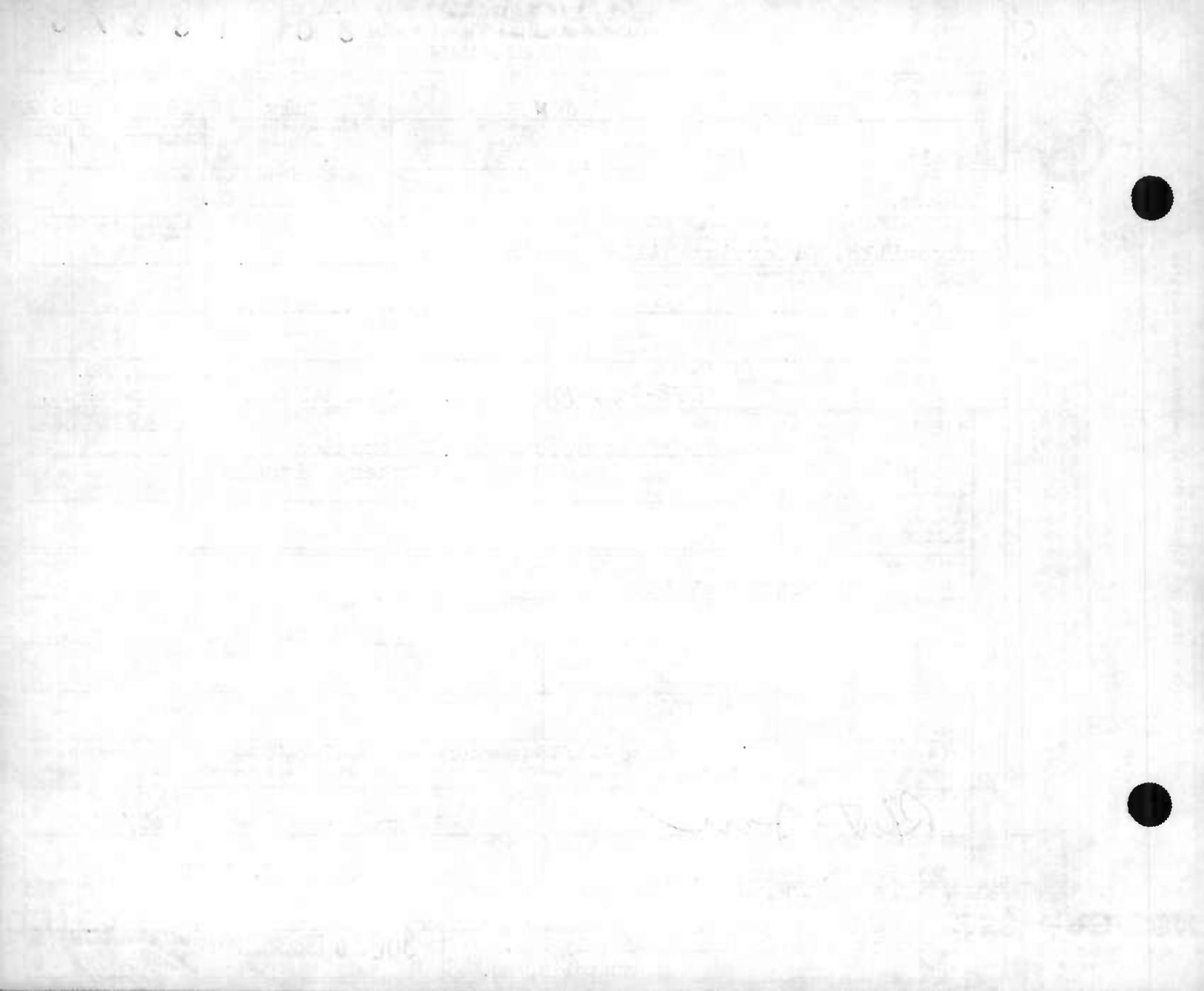
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 9 7 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

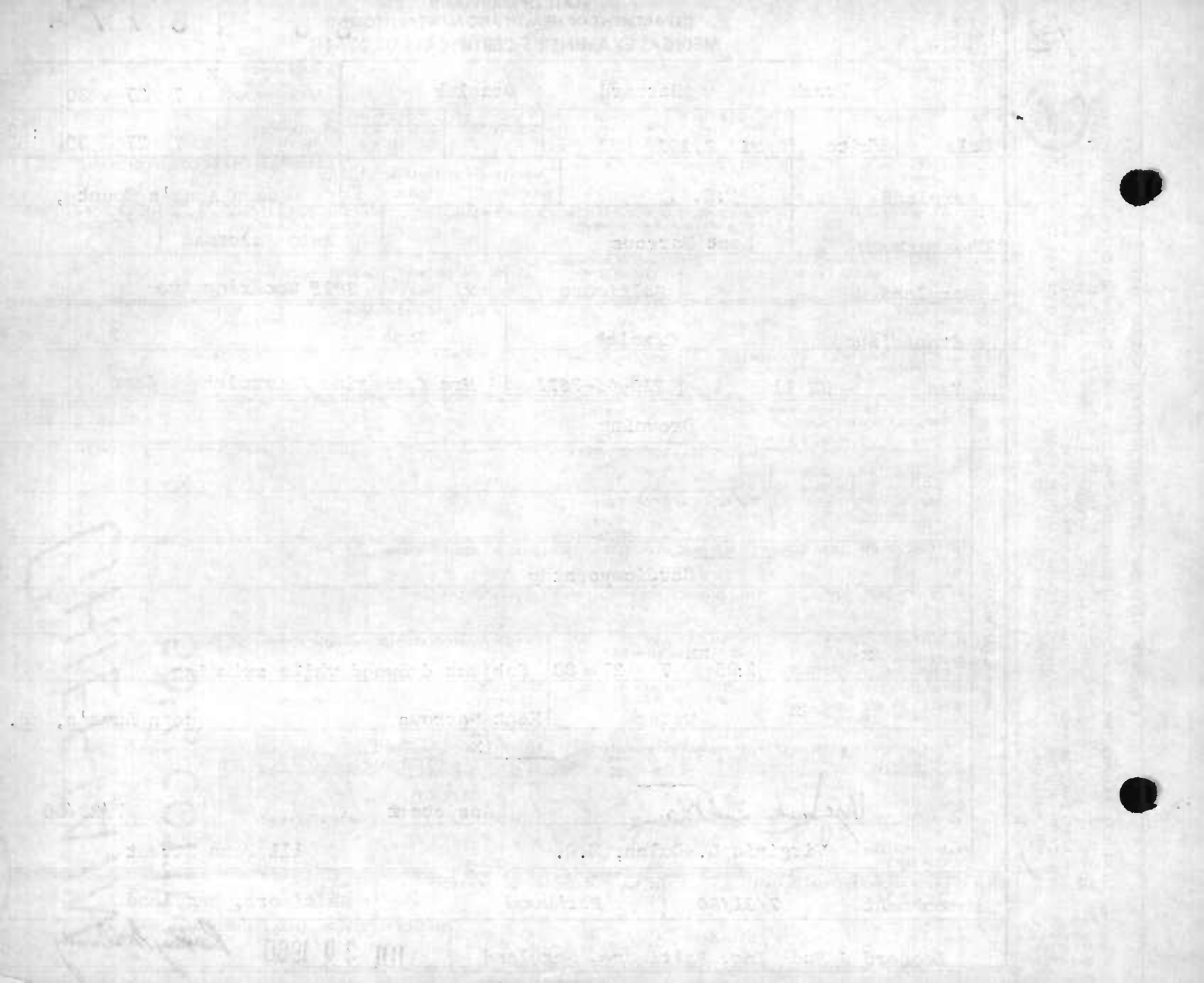
1 DECEASED NAME (TYPE OR PRINT) <b>FLORENCE JONES</b>			2a DATE OF DEATH MONTH DAY YEAR <b>July 6 1980</b>			2b HOUR <b>3:45 AM</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>August 30 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		# UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		# UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Annes Co.</b> MD					
10 CITY OR TOWN OF DEATH <b>Centreville, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Corsica Hills Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Defense Dept.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Ret. US Gov.</b>			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>Md.</b>		13c COUNTY <b>AACo.</b>		13d CITY OR TOWN <b>Deale</b>		13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f STREET ADDRESS <b>Rt. 1 Box 214</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Issac H. Jones</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian White</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b SOCIAL SECURITY NO <b>578-32-6370</b>		17 INFORMANT ADDRESS <b>Abel J. Merrill 182 Duke of Gloucester St. Annapolis, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Myocardial Infarction</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>6/30/79 (about)</b> to <b>7/6/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/6/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body of the deceased.											
22b SIGNATURE <b>Robert W. Farr</b>						DEGREE <b>MD</b>		22c DATE SIGNED <b>&amp; 7/6/80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert W. Farr, M.D.</b>						22e ADDRESS <b>Chestertown, Md. 21620</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b DATE <b>7-7-80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md.</b>				
24 FUNERAL DIRECTOR'S NAME <b>Hardesty Funeral Home</b>						ADDRESS <b>12 Ridgely Ave. Annapolis, Md.</b>		25a DATE REC'D BY REGISTRAR <b>JUL 10 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PERMIT TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)										20. DATE KNOWN OF DEATH										21. HOUR																			
Frank Bernard Orzolek										8 MONTH 7 DAY 27 19 80										M																			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD		22. HOUR																									
Male		White		April 2, 1919		61 YRS.		MONTHS		DAYS		7 27 19 80		4:00 PM																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																											
Maryland				U.S.A.								Queen Anne's County, MD.																											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																											
Chestertown				Kent Narrows				Auto Salesman																															
13a. STATE										13b. COUNTY										13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Maryland																				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3015 Woodring Ave															
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS														
Stanislaus					Orzolek					Anna					Yes					WW 11					219-05-7671					Mrs Catherine A Orzolek					Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 1 DEATH WAS CAUSED BY: Drowning																																							
IMMEDIATE CAUSE (a)																																							
9102																																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																																							
(b)																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																							
Cardiomyopathy																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																			
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
										2:05 P.M. 7 27 19 80										Subject drowned while swimming																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																			
										water										Kent Narrows																			
																				Queen Anne's, Md.																			
22a. I certify that I took charge of the remains described above, held on																		Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion															
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																			
Virginia L. Dolan, M.D.										Assistant										7/28/80																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																													
										111 Penn Street																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION									
Entombment										7/31/80										Parkwood										Baltimore, Maryland									
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Leonard J Ruck Inc. Baltimore, Maryland																				JUL 30 1980										[Signature]									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

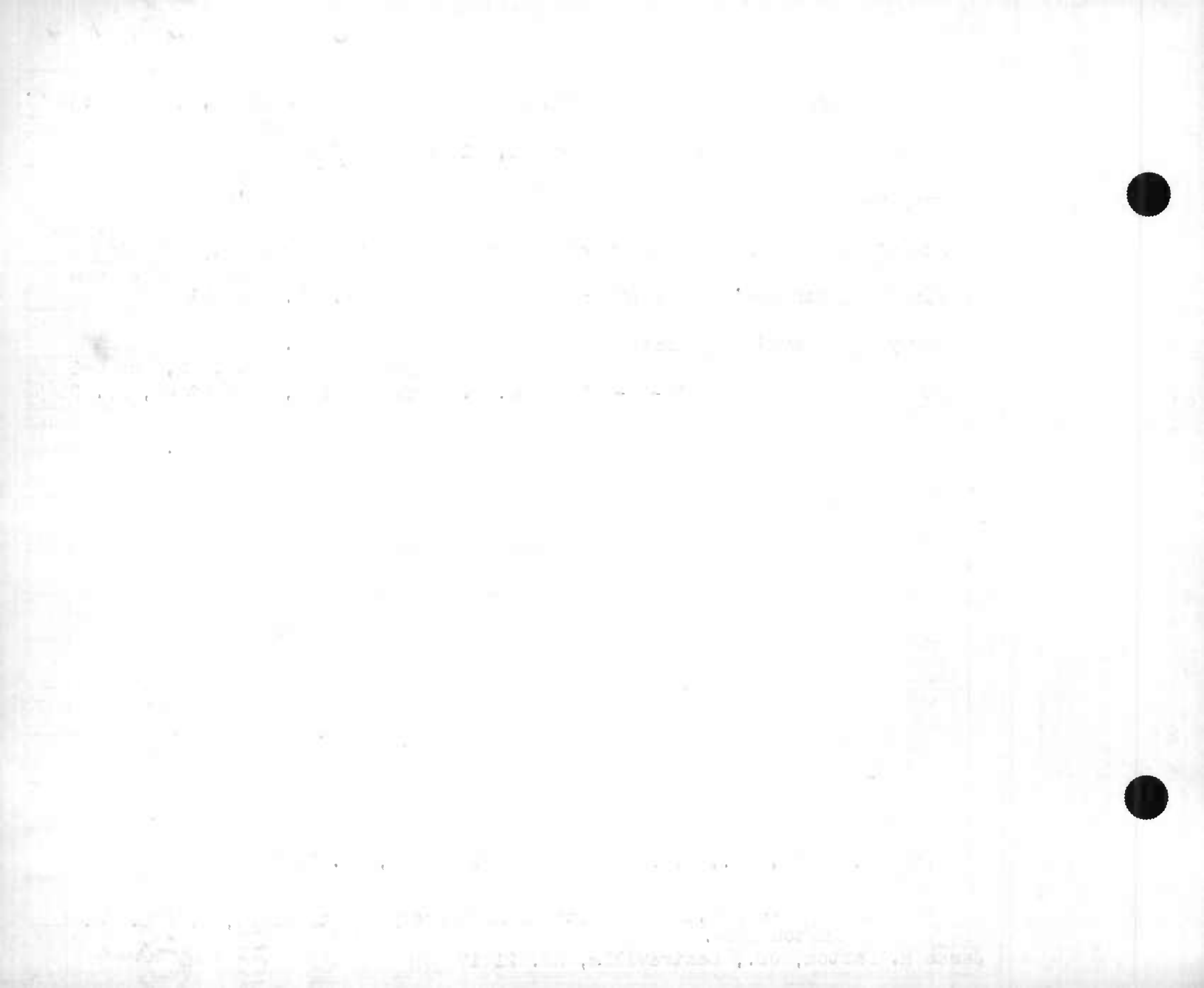
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 8 9 7 5	
FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Gordon Lee SHAWN			2a. DATE OF DEATH MONTH DAY YEAR July 7, 1980		2b. HOUR 9:50 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 1, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's MD.	
10. CITY OR TOWN OF DEATH Centreville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corsica Hills Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer (retired)		12b. KIND OF BUSINESS OR INDUSTRY General Farming
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Queen Anne's	13c. CITY OR TOWN Queenstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry David Shawn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Bell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-34-7578		17. INFORMANT Wife ADDRESS R.D. #2, Box 441 Mrs. E. Corinne Shawn, Queenstown, Md. 21658	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>a.s.c.v.D.</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 12</u> 19 <u>77</u> to <u>July 7</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 6</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death.)					
22b. SIGNATURE <u>John R. Smith, Jr.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/8/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Smith, Jr., M.D.		22e. ADDRESS Centreville, Md. 21617			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 9, 1980	23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Centreville, Q.A. Co. Md.
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 14 1980	
				25b. REGISTRAR'S SIGNATURE <u>L. H. McCreedy</u>	

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

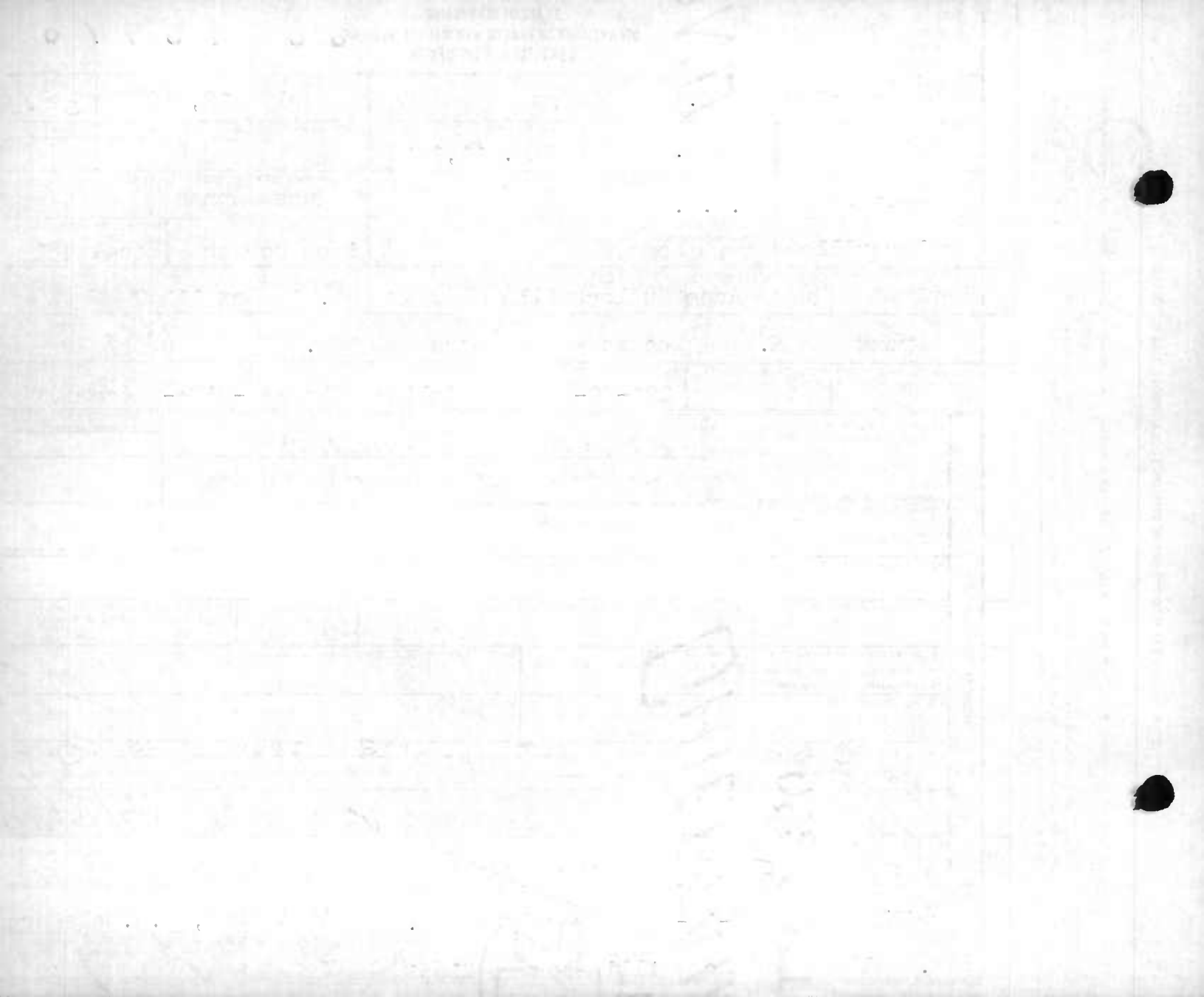
1. DECEASED NAME (TYPE OR PRINT) <b>Reynolds M. Thomas</b>			2a. DATE OF DEATH MONTH <b>July</b> DAY <b>13</b> YEAR <b>1980</b>			2b. HOUR <b>3:00</b> AM					
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>11</b> YEAR <b>1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Annes</b> MD		
10. CITY OR TOWN OF DEATH <b>Sudlersville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>iron worker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Local 451</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Queen Anne</b> 13d. CITY OR TOWN <b>Sudlersville</b>						13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13f. STREET ADDRESS <b>Rt. 1 Box 111 C</b>		
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>H.</b> LAST <b>Thomas</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Cora</b> MIDDLE <b>F.</b> LAST <b>Murphy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>221-09-9650</b>			17. INFORMANT ADDRESS <b>Madeline Thomas -wife- (same)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF <b>RECTUM + BLADDER</b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b></b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>OCT.</b> 19 <b>1978</b> to <b>JULY</b> 19 <b>80</b> , that (1) (we) lost saw the deceased alive on <b>7/15/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Arthur F. Zimmerman</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>7/15/80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur F. Zimmerman</b>						22e. ADDRESS <b>1001 S. BRADFORD ST. Dover Del.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-16-80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gracelawn Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wilmington, N.C. Delaware</b>		
24. FUNERAL DIRECTOR NAME <b>Edw. Fellows and Son Millington MD 21651</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 22 1980</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

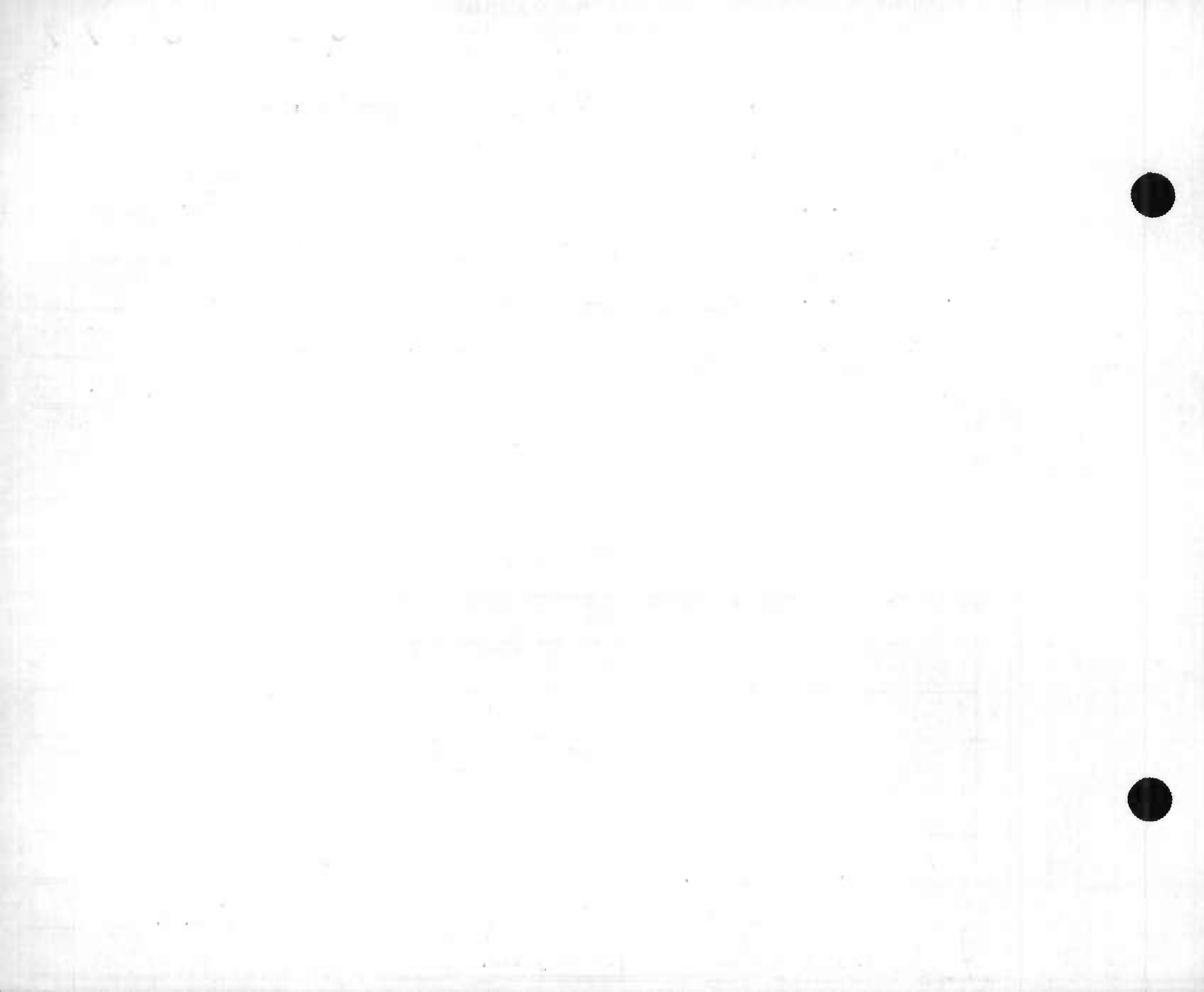
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 8 9 7 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frances B. Rosewag Tierney</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 15, 1980</b>		2b. HOUR <b>2p</b> M			
3 SEX <b>female</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 2, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Sudlersville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kitty Domicile Care Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Md. Q.A. Sudlersville</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>?</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Rosewag</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth May</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577 16 5338</b>		17. INFORMANT ADDRESS <b>May Grossnickle Chestertown, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Thrombosis</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.H.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>5 yrs</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1979</b> , to <b>July 15, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 11, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John R. Smith, Jr.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>7/15/80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Smith, Jr.</b>						22e. ADDRESS <b>Centreville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/16/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>					
24. FUNERAL DIRECTOR NAME <b>John W. Wells</b> ADDRESS <b>Chestertown, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>7/18/80</b>		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

18978

1. DECEASED NAME (TYPE OR PRINT) <b>Lillian Mae Walker</b>			2a. DATE KNOWN OF ESTI-MATED <input checked="" type="checkbox"/> 7 10 1980			2b. HOUR <b>11</b> P.M.		
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>July</b> DAY <b>13</b> YEAR <b>39</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>7 10 1980</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's County</b> MD		
10. CITY OR TOWN OF DEATH <b>RD#1 Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Highway</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>
13a. STATE <b>Pa.</b>			13b. COUNTY <b>Phila</b>	13c. CITY OR TOWN <b>Phila</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3522 N. 22rd St. Phila, Pa.</b>		
14. FATHER'S NAME FIRST <b>Olivier</b> MIDDLE <b>Walker</b> LAST <b>Walker</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ethel</b> MIDDLE <b>Branch</b> LAST <b>Branch</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>97-32-4921</b>		17. INFORMANT ADDRESS <b>Miss. Michelle Walker Phila, Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I DEATH WAS CAUSED BY: <b>8169 IMMEDIATE CAUSE (a) Multiple Internal Injuries</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Disturbance</b> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>129 P.M. 7- 10 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OF PART 2) <b>Auto overturned &amp; pt. sustained acute injuries - reporter DOA scene</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>		21f. LOCATION STREET <b>Rte 544</b> CITY OR TOWN <b>Kibler</b> COUNTY <b>Rd. in Chestertown</b> STATE <b>Pa.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John R. Smith Jr.</b>			TITLE (SPECIFY) <b>Reg.</b>			DATE SIGNED <b>7/14/80</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John R. Smith Jr.</b>			ADDRESS <b>M.D. Centreville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/17/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel Cem.</b>		23d. LOCATION CITY OR TOWN <b>Feasterville</b> COUNTY <b>Bucks</b> STATE <b>Pa.</b>	
24. FUNERAL DIRECTOR NAME <b>Smith Walley</b>			ADDRESS <b>Chestertown, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Lifroy K. Brady</b>

